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ABSTRACT

The pros and cons of state laws mandating mental health insurance are discussed in this report. The history of a 1985 Supreme Court case which held that states could mandate mental health benefits introduces the report. In an overview of the issue, the long-standing argument between the insurance industry and the mental health establishment is discussed, including their disagreements on consumer choice in a free market system, potential increases in service utilization and costs, and the appropriateness of the legislative arena deciding the issue. Legislative guidelines are presented for the topics of minimum benefits, persons covered, types of treatment covered, treatment settings, professionals authorized for service, and cost containment measures. Specific state laws are presented with a chart listing 26 states which mandate mental health insurance with their services, policies, and providers covered. The increased interest in mental health insurance by states and the private sector is discussed with implications for the future. A New Hampshire case study and references are included. (ABL)

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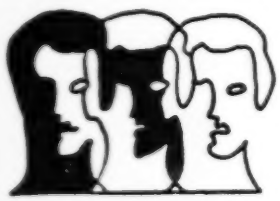

MENTAL HEALTH PROJECT

Human Resources Series

MANDATED MENTAL HEALTH INSURANCE: A COMPLEX CASE OF PROS AND CONS

by

Andrea Paterson

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MANDATED MENTAL HEALTH INSURANCE: A COMPLEX CASE OF PROS AND CONS

INTRODUCTION

On June 1, 1985, state legislatures across the country were still anxiously awaiting word from the U.S. Supreme Court on the legality of state laws requiring insurance companies to offer or provide minimum mental health benefits. Twenty-six states already had such laws; nearly all other states had considered them. Fifteen years of legislative action in this area was on hold.

The Court had yet to hand down its decision in the jointly heard case of Metropolitan Life Insurance Company v. Massachusetts and Travelers Insurance Co. v. Massachusetts. Specifically at issue was the legality of a Massachusetts law mandating certain minimum inpatient and outpatient mental health benefits in any group or individual insurance plan.

Metropolitan Life Insurance Company had charged that the state's mandated benefits law was in conflict with the federal Employee Retirement Income Security Act of 1974 (ERISA), which broadly preempts any and all state laws that regulate employee benefit plans. Massachusetts maintained that its mandated benefits law was protected by a key exception to ERISA's broad preemptive power: an exception that upheld the power of state laws regulating the business of insurance (1, p. 11).

In a different vein, the Travelers Insurance Company maintained that Massachusetts minimum benefits law was preempted by the federal National Labor Relations Act (NLRA) because it applied to benefit plans negotiated under collective bargaining agreements (1, p. 7). The state law, in effect, mandated certain terms of collective bargaining agreements by requiring the purchase of certain benefits, regardless of whether or not the parties involved wanted such benefits (2, p. 22). Massachusetts held that its law was not preempted by the NLRA because mandating minimum benefits did not upset the balance of power between the negotiating parties (2, p. 18).

On June 3rd, 1985, the Supreme Court upheld the Massachusetts law on both counts. Regarding the law's possible preemption by ERISA, the Court held that "if a state law regulates insurance, as mandated-benefits laws do, it is not preempted" (1, p. 21). Congress intended to preserve such state regulatory rights in exempting state laws governing the insurance industry from ERISA's preemptive power (1, p. 18). Regarding the law's possible preemption by the NLRA, the Court, citing the "purpose of Congress [as] the ultimate touchstone" (1, p. 22), held that Congress' intent in passing the NLRA was to establish "an equitable process for determining the terms and conditions of employment" (1, p. 28). The Court found no incompatibility "between federal rules designed to restore the equality of bargaining power and state. . .legislation that imposes minimal substantive requirements on contract terms negotiated between parties" (1, p. 29).

Across the country, legislative, professional and consumer advocates of mandated mental health insurance breathed a sigh of relief. Yet the Supreme Court decision stayed only the legal controversy surrounding these laws. Advocates and opponents alike maintain the fight is far from over. And while the Supreme Court decision has placed responsibility for mandating mental health benefits solidly back into the hands of the states, few state lawmakers would dispute the

fact that mandatory mental health benefits can be a hot political and economic issue to handle.

OVERVIEW: THE LONG-STANDING ARGUMENT BETWEEN THE INSURANCE INDUSTRY AND THE MENTAL HEALTH ESTABLISHMENT

In many state legislatures, controversy over mandated mental health insurance has largely reflected the traditional stand-off between the insurance industry and the mental health community over the necessity and appropriateness of minimum benefits laws. Points of contention between the two groups generally center on consumer choice in the free market system, potential increases in mental health services utilization and costs following a mandate, and the appropriateness of the legislative arena for deciding such an issue.

Consumer Choice in the Free-Market System. Opponents argue that mandates interfere with the market for mental health insurance and are unfair to consumers and industry alike. They maintain that mandates do the following:

- Deny employers and employees the right to choose the benefits they want. As such, the issue is not the ultimate desirability of mental health insurance, but the appropriateness of mandating such insurance when consumers have limited funds with which to buy all types of insurance coverage. The result is less consumer choice and higher premiums;

- Act as a regressive tax. As most employees pay for at least some portion of their health insurance, either through direct premiums or through decreased wages, a law that forces every employee--regardless of income--to purchase the same minimum benefits necessarily imposes a greater hardship on individuals with a lower income;

- Give an unfair advantage to insurance carriers not required to provide minimum benefits. One of the industry's toughest new competitors--Health Maintenance Organizations--are generally not covered by state mandates. In addition, individual insurance plans often are not covered;

- Encourage the trend toward self-insurance. As more companies find themselves required to purchase insurance packages containing unwanted mandated benefits, they will be more likely to self insure, thus side-stepping all federal and state regulation of employee insurance plans;

- Discourage industry from staying or locating in a state. As employers spend an average of 38 percent of their employee labor costs on benefits, a mandate that increases employee benefit costs will detract from that state's ability to attract or retain businesses (3, p. 9);

- Increase the number of uninsured employees. Small businesses may choose to drop their employee health insurance altogether if mandates increase the price of that insurance beyond an affordable point.

Proponents argue that a mandate can restore to proper functioning the otherwise improperly functioning market in mental health insurance, as well as ensure minimum coverage for individuals who need, but are unable to afford mental health insurance. To this end, proponents maintain that two key problems keep the market in mental health insurance from functioning properly.

- The average mental health consumer is not well-informed about the need for and value of mental health insurance. It is estimated that the stigma associated with mental illness helps keep four-fifths of the individuals suffering from a mental disorder from seeking treatment (4, p. 3). Many individuals also have "unrealistic feelings of immunity to mental illness" (5, p. 34), stemming in part from a general "lack of understanding of mental illness, especially when compared to physical illness" (4, p. 3). Furthermore, many employees without mental health coverage are reluctant to ask their employers for such coverage, and employees with such coverage are reluctant to use it because they fear that they will jeopardize their jobs (5, p. 34). Finally, an individual's employer and family may undervalue mental health insurance because they benefit indirectly and in ways that cannot be readily quantified.

- The market in mental health insurance is kept from functioning properly by a phenomenon known as "adverse selection." Adverse selection refers to "the tendency of high-risk policyholders to choose insurance plans with coverage they are likely to use," and for low-risk policyholders not to choose these same plans (6, p. 208); thus it changes the nature of the "risk pool" created by insurance coverage of an illness. When only those high-risk individuals, who know they will use mental health insurance, select plans offering mental health coverage, there is no real risk pool created. As most of the individuals in the pool will take advantage of the mental health services, the costs of that care are not spread evenly over a larger, randomly-selected group reflective of the true risk of mental illness among the general population. As the costs of the mental health coverage climb toward the out-of-pocket care costs, the insurance plans offering mental health coverage often have to drop or decrease that coverage to remain competitive.

Proponents of mandated insurance also maintain that it improves shallow insurance coverage for those low-income employees who would not normally have the out-of-pocket resources for mental health care, but who might need it at some point in their lives to retain their jobs and well-being. Such individuals could use their insurance to defray the costs of mental health care following, for example, the unexpected death of a child or spouse or a traumatic divorce.

Potential Increases in Mental Health Services Costs and Utilization. On the issue of the effect of mandates on mental health care costs and utilization, each side charges the other with misinterpretation of research data and flawed research designs. Moreover, both sides cite studies and statistics that refute the other's "inaccurate" findings.

Opponents argue that mandates greatly increase the costs and utilization of mental health care, without a comparable increase in benefits to individuals and society.

- Blue Cross/Blue Shield of Massachusetts reported a 24-fold increase in outpatient mental health care costs following the implementation of that state's minimum benefits law. In addition, the number of individual therapy sessions almost tripled, making it the single most common procedure covered by Blue Cross/Blue Shield (7, p. 8).

- Minnesota Blue Cross/Blue Shield, between 1976 and 1980, reported a 115 percent increase in inpatient costs for psychiatric care and chemical dependency following the implementation of that state's mandate. Overall hospital charges in the state increased by only 58.2 percent during the same period (7, p. 8).

- In Kansas, Blue Cross/Blue Shield found that the state mental health mandate added "nearly five dollars per month to the average family contract"; in Maryland, Blue Cross/Blue Shield found the increase to be "between two and three dollars per month per family contract" (3, p. 5).

Opponents maintain that mandates produce this dramatic increase in costs and utilization for several reasons. First of all, without providing adequate provider incentives to control costs, they greatly expand provider markets.

- Minimum mental health benefit laws have been associated with average statewide increases of 7 percent in the number of psychiatrists and 32 percent in the number of psychologists (8, p. 207).

- In Wisconsin, the number of state-approved outpatient clinics, for the treatment of drug and alcohol abuse and mental illness, soared from under 40 to over 900 following the implementation of that state's minimum benefits law (9, p. 2)

Secondly, opponents maintain that the amount of mental health care that a consumer will use depends largely on the price of those services, so utilization can and often does skyrocket in situations of greatly increased access to mental health services.

- Between 1974 and 1981, under the liberal mental health coverage provided by the Blue Cross/Blue Shield federal employee benefits plan (FEB), the number of visits to a psychiatrist per 1000 individuals increased 34.1 percent. Yet the number of visits to psychologists, social workers and other non-medical therapists rose over 300 percent. In 1981, the combined total for FEB subscribers was 922.5 visits per 1000 individuals (7, p. 7).

- A group of Philadelphia area employers, who reviewed hospital utilization by their employees, found that "intensity of hospitalization increases dramatically with availability of benefits. . . .[and] the patients with the more generous benefits have much longer lengths of stay" (7, p. 9).

Proponents argue that mental health costs and utilization stabilize over time, that direct savings will result if an individual in need receives appropriate mental health care, and that mandates can be implemented in such a way as to control unnecessary use of mental health services. Regarding the stable costs and utilization of mental health care over time, proponents cite such examples as the following:

- A 1982 study indicated that the percentage of federal employees receiving psychiatric benefits under both the Blue Cross/Blue Shield and Aetna federal employee benefit plans is relatively stable at around 1.5 percent of the total number of enrollees (6, p. 8).

Proponents insist that the insurance industry's claim of greatly increased costs is reflective of the fact that mandates force "insurers [to] pick up the tab that was once paid by the government and the users themselves (8, p. 207).

States presently pay 50 percent of the costs associated with mental health care, while the insurance industry pays only 12 percent. In contrast, states pay only 15 percent and private insurance dollars pay 28 percent of the costs of general medical care. The net increase in costs of a mental health mandate is estimated to be $1 to $2 per person for the general population (8, p. 208).

Proponents also claim that appropriate mental health care results in direct financial benefits to individuals, employers and society. They maintain that "attempting to establish a false dichotomy between mental and physical illness leads to a false economy in insurance coverage" (6, p. 8).

- Individuals suffering from mental disorders "will use their medical-surgical benefits to cover but not treat their diseases if they do not have access to mental health services" (4, p. 12).

- Mental health care can decrease the use of other--and often more costly--medical services. A Blue Cross/Blue Shield study of individuals diagnosed as having one of four chronic diseases, including certain types of heart disease, hypertension and diabetes found that "the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it" (10, p. 428). In general, reductions in other medical costs resulting from the provision of appropriate mental health treatment range from 5 to 80 percent (8, p. 208).

- Sixty-six percent of the $237.6 billion that drug abuse, alcoholism and mental illness cost society in 1984 was paid out in indirect costs such as decreased job productivity and loss of employment (11, p. 16). An increase in direct expenditures for mental health care could thus produce a significant decrease in indirect costs; even minimal psychotherapy has often been attributed with creating "lessening absenteeism, increasing productivity and decreasing the number of on-the-job accidents (4, p. 7).

Finally, co-payments and co-insurance provisions as well as peer review of psychiatric claims can be effective in controlling excessive and unnecessary use of psychiatric services.

- A 1985 study found "employee insulation from cost" to be the greatest factor contributing to excessive health care costs (4, p. 9).

- More than 400 psychiatrists review mental health benefit claims, based on peer review guidelines developed by the American Psychiatric Association, for 24 national and local insurers across the country. Aetna Life and Casualty spent $20,000 on such peer review in 1981, and saved an estimated $2.4 million. Mutual of Omaha's estimated savings totaled $300,000 during its first year of formal peer review procedures (6, pp. 10-11).

Appropriateness of Legislative Arena for Deciding Insurance Questions. Opponents argue that the state legislature is simply not an appropriate place for questions of insurance coverage to be decided. They maintain that the insurance industry is in the best position to judge the most cost-effective and appropriate mental health benefits on a plan-by-plan basis.

Moreover, they maintain that mental health mandates often have proven to be more costly than mandates for other types of health care. In 1984, Maryland Blue Cross/Blue Shield reported that inpatient and outpatient mental health care

accounted for 60 percent of its expenditures per member month for mandated benefits. In addition to mental health, Maryland law requires coverage of prosthetic devices, alcohol rehabilitation, home health care, as well as services rendered by podiatrists, chiropractors and optometrists, to name a few (12, p. 14).

Opponents also charge that mandating one set of benefits that expands the market for one group of care providers sets a dangerous precedent for the next special interest group that hopes to increase the currency and utilization of its services through mandates. Finally, opponents maintain that legislative efforts to provide coverage for mental health care on a par with that provided for physical illnesses are misguided. The insurance industry generally defends its track record on mental coverage by insisting that mental illness is different from physical illness: "diagnoses are subjective, protocols of treatment are unclear, providers of services are more numerous and less well-trained than is true of medical conditions" (7, p. 1).

Proponents argue that state mandates are an appropriate way to restore competition to a mental health insurance market otherwise riddled by the forces of adverse selection. They cite a long tradition of government intervention in improperly functioning markets--a tradition evidenced, for example, by the extensive body of federal and state anti-trust laws.

Proponents also argue that the insurance industry's power over mental health coverage has led to a history of employee health benefits in which "the human mind has been treated as a second class citizen" (4, apx. a). Employers often do not regard mental health benefits as essential in part because insurance companies generally refrain from promoting them.

In addition, insurance plans heavily favor inpatient care for mental health disorders, while rarely providing it at a level on a par with the coverage provided for physical illnesses. Moreover, proponents claim that the insurance industry's reliance on inpatient care for mental illness reflects a resistance to incorporating new methods of treatment for mental disorders, many of which rely on less-restrictive treatment settings.

- In 1983, the American Psychiatric Association found that, out of 300 insurance plans covering 33 million employees and their dependents, all provided coverage for inpatient care, but only 49 percent of the plans provided coverage on a par with other physical illnesses (6, p. 7). A 1985 update of that study indicated that the number of plans offering such comprehensive coverage had dropped to 48 percent (4, p. 5). Moreover, while 98 percent of the plans provided coverage for outpatient treatment, only 10 percent provided such treatment on the same basis as other medical conditions (6, p. 7).

Proponents maintain that mandated benefits requiring a mix of inpatient and outpatient services could help combat discrimination against the mentally ill in insurance coverage and provide individuals with an appropriate mix of inpatient, outpatient and partial-hospitalization services. Outpatient and partial hospitalization services have been proven to be a more cost-effective and therapeutic type of treatment for many mentally ill individuals, which can avert the potential harm of unnecessary inpatient hospitalization (5, p 38).

GENERAL LEGISLATIVE GUIDELINES: SPECIFIC STATE ISSUES IN MANDATING OR EXPANDING MENTAL HEALTH INSURANCE COVERAGE

Lawmakers must consider carefully the arguments both in favor of and against mandated mental health insurance in deciding to introduce such legislation or to support or oppose it. Specifically, state legislators should pay close attention to the key questions relative to mandating minimum mental health coverage.

What is the nature of the law? Are minimum benefits required or is the availability of such benefits mandatory? Minimum benefits packages can increase the costs of consumers' premiums and of insurance dollars paid for mental health care, so they generally incite fierce opposition from the insurance industry. Yet mandatory availability of mental health insurance coverage--often considered as a political compromise--can allow the forces of adverse selection to continue to operate, thus perpetuating the improper functioning of the mental health insurance market.

Who is covered? Insurance policies usually differentiate between those individuals who wish to improve their overall mental health and those who are ill as a result of a mental disorder; in general, insurance policies only cover treatment provided to the latter. In addition, most insurance policies limit the mental health services they cover so as to preclude any long-term treatment for mental illness. Costs of mental health care can go up considerably when more long-term treatment is brought under a mandate. Many argue, however, that those who do not receive appropriate mental health care, whatever the duration, will simply continue to use inappropriate medical services, drain the public mental health system and drive up the indirect costs of mental illness to society.

What types of treatment are covered? Minimum coverage generally applies to inpatient and outpatient services, while other laws may also require coverage of such services as partial-hospitalization. Inpatient care can often be necessary for mental disorders of an acute and intensive nature. It can be harmful, however, if treatment in such a restrictive setting is not clinically necessary. In addition, many state commitment laws restrict involuntary hospitalization to those cases in which the patient presents a clear and present danger to himself or to others. If clinically feasible, partial hospitalization and outpatient care are generally preferred treatment alternatives because they minimize the patient's dislocation and allow him or her to retain the use of natural support systems. In some localities, however, treatment settings and programs that offer accountable, commmunity-based outpatient and partial-hospitalization services are less readily available.

What coverage is provided? The problem with legislative determination of minimum levels of mental health coverage is that they tend to become maximum levels. Thus, those mentally ill who require more extensive treatment may not receive it. Still, select mandatory coverage in this area tends toward a norm.

- Most state laws mandate minimum inpatient care coverage of at least 30 days per year in a general or psychiatric hospital or some type of authorized mental health care facility; at least four states require inpatient care for psychiatric disorders to be of equal value with that provided for physical illnesses (13, p. 1.6). Many states that require coverage for partial hospitalization allow twice the number of partial hospitalization days as inpatient days (13, p. 1.7).

- State laws requiring or offering mental health benefits vary greatly with respect to outpatient treatment. Statutes can require coverage for a certain number of outpatient visits, for treatment provided up to a dollar limit or for some combination thereof. For example, Tennessee covers 30 outpatient visits per year; Georgia covers 48-50 visits per year, depending on the type of policy. Florida covers outpatient treatment up to $1,000; Massachusetts covers $500 per year. Minnesota provides for coverage of at least 80 percent of the first $750 of outpatient treatment; Vermont provides full coverage for the first five outpatient visits, and 80 percent of the treatment costs up to $500 after the first five visits.

What types of treatment settings are covered? Most state laws cover inpatient and outpatient care provided in traditional settings such as general or psychiatric hospitals or community mental health centers (CMHCs). Other laws cover additional community care providers such as free standing clinics. An increase in the number of treatment settings covered can increase utilization, but it can also help ensure appropriate treatment as well as use of the least restrictive--and least expensive--treatment setting.

Which mental health professionals are authorized to provide services? Many state laws cover only physicians and licensed psychologists. Others include such providers as clinical social workers and psychiatric nurses. Increasing the number of service providers can improve access and decrease the per unit cost of mental health care through increased competition among providers. Yet increasing the number of service providers can increase the total costs of mental health care as a result of increased utilization.

What cost containment mechanisms does the law contain? As with insurance coverage of physical illness, copayments and monetary caps can effectively limit unnecessary use of mental health services, but they can also discourage appropriate use of mental health services if they are too restrictive. Where copayments are specified, they are often 50 percent of the treatment costs once the appropriate deductible has been subtracted (13, p. 1.7). (The standard deductible for physical illness is 20 percent.) Provisions for peer review prior to reimbursement for services can effectively limit unnecessary provision of services by providers.

What types of policies are required to provide the minimum level of services? All mandated benefits laws cover group insurance policies; many cover individual policies as well. Requiring individual insurance policies to provide the minimum benefits necessarily ensures that such benefits are available. But it can also discriminate against and raise premium costs for a well-informed consumer who knows with a much greater certainty than a large corporation buying on behalf of its employees whether or not such benefits are necessary. Moreover, including both group and individual insurance plans can increase the trend towards self-insurance among employers and individuals.

THE STATES' RESPONSE IN RECENT YEARS

The following chart delineates the existing 26 state minimum benefits laws with respect to the type of mandate, the year passed and the services, policies and providers covered. In 1985, at least six states (Alaska, Hawaii, Indiana, Iowa, Mississippi and Oklahoma) considered legislation mandating minimum mental health benefits or the availability of such benefits, but none passed it. In

1986, similar legislation has already been introduced in five states (Alabama, Hawaii, New Jersey, New York and Utah).

At present, 12 states require minimum benefits, 12 states require the availability of such benefits and two states require coverage for certain services and the availability of coverage for others. Connecticut was the first state to pass such a law in 1971; Georgia and Oregon were the most recent states to pass such legislation in 1984. The majority of the states passed their laws in the mid-to-late 1970s. The statutes in 23 states cover inpatient care, 24 cover outpatient care and nine cover partial hospitalization. (Wisconsin's law does not specify the types of services covered: it merely stipulates that coverage is provided for treatment of mental illness at usual and customary rates.) All 26 states cover group policies; nine cover individual policies as well. All cover services provided by a physician, 24 cover services provided by a licensed psychologist, 12 cover services provided by a licensed or clinical social worker and six provide coverage for additional service providers including psychiatric nurses, marriage and family counselors, licensed psychotherapists and pastoral counselors (see chart of state laws, p. 11).

FUTURE IMPLICATIONS AND DIRECTIONS

The track record of recent legislative attempts to pass mandated mental health legislation may or may not indicate that a plateau has been reached among the states that plan to adopt such measures. Many state lawmakers suspended their efforts in this area pending the Supreme Court's decision in Metropolitan Life v. Massachusetts. According to the National Mental Health Association, legislative interest in mental health mandates has risen considerably since the Supreme Court upheld the Massachusetts law.

Efforts among those states that already have mandates are largely focused on updating or expanding their laws. A number of states have considered legislation to expand the number of service providers covered by the mandate. In 1986, Maryland, Minnesota, and New Hampshire are all considering legislation to put Health Maintenance Organizations (HMOs) under their mandates. Massachusetts is considering legislation to include specialists in psychiatric and mental health nursing, Minnesota to include certified psychologists, and New Hampshire to include clinical social workers. In 1985, California, New York, and West Virginia considered, but did not pass, legislation that would have made mandatory the mental health coverage that is presently optional in all insurance policies. In 1986, Maryland decreased from 50 to 40 percent the copayment on outpatient mental health care (1986 Md. Laws, chap. 843).

States are also beginning to act on quality assurance and utilization review. In 1985, the Oregon State Health Planning and Development Agency issued the first of two required reports evaluating the effectiveness of that state's 1984 benefits law, which mandated coverage for outpatient and partial hospitalization services and significantly reduced inpatient care coverage.

The statute allowed insurers two cost containment options, one of which was adopted by Blue Cross/Blue Shield of Oregon and seems likely to be adopted by other Oregon insurers: professional peer review of reimbursement claims, evaluated for both the level of care and length of treatment. While the report acknowledges certain problems with the existing statute, it does state that in Oregon "more people are currently receiving services for less money" than were previously. It notes that nominal increases in outpatient care costs have been

offset by marked decreases in inpatient care costs for both Blue Cross/Blue Shield and SelectCare (14, p. 10).

States must remember, however, that much of the research relative to the impact of state minimum benefits has yielded conflicting evidence. Both the insurance industry and the mental health community dispute each other's statistics, citing flaws in research design and biased interpretation of data. Moreover, in 1984-85, the Baltimore, Maryland-based Center for Health Policy Studies undertook a major review of the literature relevant to mandated mental health insurance and made recommendations regarding further research. The report cited methodological inconsistencies in the research that had been done, such as differences in provider settings and the use of health insurance claims as research data, as cause for this conflicting evidence (13, pp. 1.12, 3.58). Thus state legislators must remember to evaluate the effectiveness of a minimum benefits law in light of the mental health system and resources within their own state.

Finally, the private sector also has begun to address more aggressively the issue of mental health care for employees. In deciding to support or oppose mandated mental health insurance, state legislators would want to weigh carefully any changes in the corporate world's overall approach to combating mental illness. For example, a 1984 survey of 64, mostly Fortune 500, companies with over 19 million employees indicated substantive changes in approach to mental health care:

- 19 percent had recently increased their lifetime or annual maximums for mental health coverage;
- 22 percent had recently enhanced their coverage for outpatient services, with an additional eight percent planning to increase outpatient coverage in the near future;
- 73 percent had developed Employee Assistance Programs (EAPs) to combat the problems associated with emotional problems and alcohol and drug abuse. While 30 percent of the EAPs still focused on alcohol and drug abuse intervention and treatment, 68 percent had broadened their scope to include short-term mental health treatment;
- 41 percent had implemented stress management programs (15, pp 15-16).

STATE MANDATORY MENTAL HEALTH INSURANCE LAWS

STATE	MANDATE TYPE: MANDATED BENEFITS PACKAGE	MANDATED AVAILABILITY	YEAR	SERVICES COVERED: INPATIENT	OUTPATIENT	PARTIAL HOSPITALIZATION	POLICIES COVERED: GROUP	INDIVIDUAL	ADDITIONAL PROVIDERS COVERED: PSYCHOLOGISTS	SOCIAL WORKERS	OTHER
AR	X		1979	X	X		X	X	X		
CA		X	1973	X	X		X		X	X	(1)
CO	X		1976	X	X	X	X		X		
CT	X		1971	X	X	X	X	X	X	X	
FL		X	1976/83	X	X	X	X		X		
GA		X	1984	X	X		X	X	X		
IL		X	1975	X	X		X	X	X		
KS		X	1978	X	X		X		X	X	
LA		X	1975	X	X		X		X	X	
ME	X		1983	X	X	X	X		X	X	(2)
MD	X		1974	X	X		X	X	X	X	
		X				X	X				
MA	X		1973	X	X		X	X	X	X	(3)
MN	X		1975	X	X		X				
MO		X	1980	X	X		X	X			
MT	X		1983	X	X		X		X	X	
NH	X		1975	X	X	X	X		X		(4)
NY		X	1977	X	X		X		X	X	
ND	X		1975	X		X	X				
OH	X		1978		X		X		X		
OR	X		1984	X	X	X	X		X	X	(5)
TN		X	1974		X		X		X		
VT		X	1975	X	X	X	X		X		
VA	X		1975	X			X	X	X	X	
		X	1975		X		X		X	X	
WA		X	1983	--see note #6--			X		X		
WV		X	1977	X	X		X	X	X		(7)
WI	X		1975/85	X	X		X				

1) psychiatric nurses and licensed marriage, family and child counselors

2) psychiatric nurses

3) licensed psychotherapists

4) licensed pastoral counselors

5) nurse practitioners

6) Coverage provided for treatment at usual and customary rates, subject to reasonable deductibles and copayments, for services provided by a licensed physician, a licensed psychologist or a licensed community mental health agency.

7) licensed psychotherapists

NEW HAMPSHIRE CASE STUDY: THE PROS AND CONS OF EXPANDING EXISTING MENTAL HEALTH BENEFITS

New Hampshire's current mental health benefits law, passed in 1975 and implemented in 1977, requires certain minimum mental health coverage in all group insurance policies. The law differs from many state mandated benefits laws in that it differentiates between major medical and non-major medical insurance policies and contracts. Major medical policies must provide inpatient, partial hospitalization and outpatient services for mental illness on a par with other illnesses, with an annual limit of $3,000 and a lifetime limit of $10,000. Non-major medical policies must cover 15 hours of outpatient care, with the patient assuming the cost of the first two visits.

As a result of the law, the New Hampshire state hospital and the CMHCs have reaped substantial benefits from shifting costs.

- The state bills about $450,000 per year to private insurers for care provided in the New Hampshire State Hospital. This return on care provided to insured individuals helps defray the costs of that care and ensure that state funds are only used for truly catastrophic mental health problems that require long-term care and treatment of an acute nature (16).

- In 1986, New Hampshire's CMHCs will receive an estimated $4.5 million from private insurers for care provided in local settings and covered by the state mandate (16). These savings to the CMHCs are critical to ensure the availability of many community-based counseling and mental health care services that cannot be, by state law, paid for by state dollars. Without reimbursement from private insurers, these services might not exist. New Hampshire state law stipulates that state funds can be used only for the severely and chronically mentally ill, and for mentally ill elderly or children (16).

Blue Cross/Blue Shield of New Hampshire opposed the original law and opposes the currently proposed amendments to it. As reason for its past and present opposition, the insurer cites dramatic increases in its own costs for mental health care as well as the questionable effectiveness of the law's cost containment measures.

- Between 1977 and 1981, Blue Cross/Blue Shield increased by 245.4 percent the amount that it paid to the state's CMHCs for mental health care. During the same period, rates charged by the CMHCs increased 30 percent more than the rates charged by private psychiatrists (17).

- Inpatient claims have remained constant and the average length of stay in an inpatient psychiatric facility has gone up from 19 to 22 days (17).

- Eighty-two billing units of psychologists and pastoral counselors now qualify for reimbursement, as opposed to the 13 psychologists who qualified for reimbursement prior to the mandate, indicating a rapid growth in service providers following the mandate (17).

A number of legislative proposals are currently being considered in New Hampshire related to the state's mandated mental health law. These proposals include:

- Increasing the minimum outpatient coverage from 17 outpatient visits to 25 visits, with no more than a 50 percent copayment and an annual cap of $2500;

- Expanding the number of eligible service providers to include clinical social workers;

- Extending the mandate to include Health Maintenance Organizations (HMOs).

The state is also studying the possible implementation of some type of quality assurance or utilization review procedure to ensure that the mental health services provided under the mandate are necessary and of high quality.

The NCSL Mental Health Project conducted a technical assistance program for New Hampshire in January 1986 to help educate legislators and staff about the possible consequences of and alternatives to the proposed changes in the state's minimum benefits laws. Participating in the program was Dr. Richard Frank, mental health economist, Johns Hopkins University, Baltimore, Maryland. The suggestions provided to New Hampshire do not necessarily reflect those of NCSL or the National Institute of Mental Health.

ARGUMENTS FOR AND AGAINST THE PROPOSED CHANGES IN NEW HAMPSHIRE'S LAW

Increasing the mandate. Increasing the mental health benefits required can increase utilization and costs as well as the amount of the regressive tax that mandates impose on working individuals. Yet an increase in benefit levels will mitigate further the forces of adverse selection in the market for mental health insurance and transfer more of the costs for mental health care from individuals and the public sector to the private sector.

Increasing the number of eligible service providers to include social workers. Increasing the number of eligible service providers can increase the utilization and costs of mental health services and shift a greater percentage of the costs of mental health care to the private insurance industry. Yet an increase in the number of service providers can increase consumer access. In addition, including social workers could encourage more competition among existing service providers, thus decreasing the per unit cost of mental health care and increasing the quality of care since providers will need to ensure high quality care in order to retain their clients.

Including HMOs under the mandate. Including HMOs under the mandate would decrease their competitive edge against traditional insurance carriers already covered by the mandate and would spread the risk of mental health care costs over a greater number of individuals. Yet including HMOs could accelerate the trend toward self-insurance among those businesses and individuals striving to hold down their health care costs.

SOLUTIONS THAT COULD BRING PROS AND CONS INTO AN APPROPRIATE BALANCE

Increase the minimum coverage and the number of service providers in conjunction with other cost containment mechanisms. New Hampshire could move ahead with legislation designed to increase the minimum coverage required under the mandate and to expand the number of service providers if it made use of other cost containment measures that would offset the increased use of mental health services that such a dual increase in coverage and eligible service providers

would probably bring about. Examples of such containment measures that could be employed include:

- Increasing deductibles or copayment rates;

- Limiting increases in outpatient coverage to roughly 25 visits, after which the offset effects of mental health care on use of medical care tend to decrease.

Implement some type of vigorous utilization review and quality assurance programs. The state could also work to control upward pressure on utilization if it implemented some type of quality assurance or utilization review procedure. New Hampshire may wish to consult the American Psychiatric Association's guidelines for peer review of psychiatric claims and the American Psychological Association's guidelines for peer review of psychological claims. Such peer review programs have already been credited with saving millions of dollars nationwide.

Along this line, New Hampshire may want to consider bringing HMOs under the mandate, as they have both the administrative ability to control costs and the incentives to control utilization.

CONCLUSION

Since New Hampshire's experience with its present mental health mandate has been generally positive, the state would want to weigh carefully any possible amendments to the law before proceeding. Yet if the state decides to move ahead with proposed changes, it can move ahead with the knowledge that the present law will provide a solid foundation for further actions in this area.

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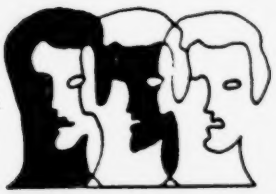

MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In February 1985, the National Institute of Mental Health (NIMH), U. S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues.

The goal of the NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information surrounding mental health issues.

Through this fourteen month program, the Mental Health Project can respond to specific issue and format needs of legislators. By involving the Panel of Experts, a group composed of legislators and persons with mental health experience, expert consultants, and state policy makers, programs will be developed to provide a variety of services to states, including testimony, special workshops and seminars, and staff assistance.

Based upon input from the state legislatures, ten states were chosen to receive technical assistance with state-specific mental health issues. Along with the programs, background materials, audio tapes, and a State Legislative Report will be developed for each issue area and are available free of charge to requesting parties. The scheduled technical assistance programs include:

South Carolina	Involuntary Civil Commitment	May 10, 1985
California	Mentally Ill Homeless	August 7, 1985
Missouri	Mental Health Services Coordination	September 24, 1985
Kentucky	Mental Health Services for Adolescents	October 3-4, 1985
Pennsylvania	Revolving Door Syndrome of Mental Health Services	October 23, 1985
Virginia	Housing for the Mentally Ill	November 18, 1985
Oklahoma	Community Care for the Chronically Mentally Ill	December 4-5, 1985
New Hampshire	Mandated Mental Health Insurance/ Mental Health Services for the Elderly	January 9, 1986
Michigan	Mentally Ill Offender	January 28, 1986
Oregon	Mental Health Services Funding	March 4, 1986

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